PERSONAL INFORMATION

Today's date ___________________________

First name _____________________________ Middle Initial _________________ Last Name ___________________________

I prefer to be called ____ Male ________ Female ________

Address ____ City ____________________Town ________ Post Code _______

Date of Birth ____ Passport No # ____

Mobile Phone ________________________ Work Phone _________________________ Home Phone _______________________

Do we have permission to text you? Yes ____ No ____

Primary contact number (Check one) Cell _______ Work ________ Home ________

Email ____ Employer ____

Spouse's Name ______________________________________ Spouse's Employer _______________________________________

Whom may we thank for referring you? ____

Emergency contact person / contact number ____

DENTAL INFORMATION

Reason's for today's visit ____

Are you currently in pain? Yes ____ No _____ If so please describe ____

Do you have any dental problems right now? Yes ____ No ____ If so please describe __________________________________

Have you ever had problems with previous dental treatment? Yes ____ No ______

If so please describe ____

Anything we can do to improve upon your last dental treatments? ____

Please rate your level of anxiety about seeing the dentist (least) 1 2 3 4 5 (most)

MEDICAL HISTORY

PATIEN'S NAME ______________________________ BIRTH DATE ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	O Yes	O No	If yes, please explain: ______
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes, please explain: ______
Have you ever had a serious head or neck injury?	O Yes	O No	If yes, please explain: ______
Are you taking any medications, pills, or drugs?	O Yes	O No	If yes, please explain: ______
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	______
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes	O No	______
Are you on a special diet?	O Yes	O No	______
Do you use tobacco?	O Yes	O No	
Do you use controlled substances?	O Yes	O No	______

WOMEN:
Are you Pregnant/Trying to get pregnant? O Yes O No   Taking oral contraceptives? O Yes O No   Nursing? O Yes O No

Do you have, or have you had, any of the following?

Condition		
AIDS/HIV Positive	O Yes	O No
Alzheimer's Disease	O Yes	O No
Anemia Angina	O Yes	O No
Artificial Heart Valve	O Yes	O No
Artificial Joint	O Yes	O No
Asthma	O Yes	O No
Blood Disease	O Yes	O No
Blood Transfusion	O Yes	O No
Arthritis/Gout	O Yes	O No

Condition		
Breathing Problem	O Yes	O No
Bruise Easily	O Yes	O No
Cancer	O Yes	O No
Chemotherapy	O Yes	O No
Chest Pains	O Yes	O No
Cold Sores/Fever Blister	O Yes	O No
Congenital Heart Disorder	O Yes	O No
Convulsions	O Yes	O No
Drug Addiction	O Yes	O No

Condition		
Cortisone Medicine	O Yes	O No
Diabetes	O Yes	O No
Easily Winded	O Yes	O No
Emphysema	O Yes	O No
Epilepsy or Seizures	O Yes	O No
Excessive Bleeding	O Yes	O No
Excessive Thirst	O Yes	O No
Fainting Spells/Dizziness	O Yes	O No
Frequent Cough	O Yes	O No

Do you have, or have you had, any of the following?

Condition	Yes	No
Frequent Diarrhea	O Yes	O No
Frequent Headaches	O Yes	O No
Genital Herpes	O Yes	O No
Glaucoma	O Yes	O No
Hay Fever	O Yes	O No
Heart Attack/Failure	O Yes	O No
Heart Murmur	O Yes	O No
Heart Pacemaker	O Yes	O No
Heart Trouble/Disease	O Yes	O No
Hemophilia	O Yes	O No
Hepatitis A	O Yes	O No
Hepatitis B or C	O Yes	O No
Herpes	O Yes	O No
High Blood Pressure	O Yes	O No
High Cholesterol	O Yes	O No
Hives or Rash	O Yes	O No
Hypoglycemia	O Yes	O No
Irregular Heartbeat	O Yes	O No
Kidney Problems	O Yes	O No
Leukemia	O Yes	O No
Liver Disease	O Yes	O No
Low Blood Pressure	O Yes	O No
Lung Disease	O Yes	O No
Mitral Valve Prolapse	O Yes	O No
Osteoporosis	O Yes	O No
Pain in Jaw Joints	O Yes	O No
Parathyroid Disease	O Yes	O No
Psychiatric Care	O Yes	O No
Radiation Treatments	O Yes	O No
Recent Weight Loss	O Yes	O No
Renal Dialysis	O Yes	O No
Rheumatic Fever	O Yes	O No
Rheumatism	O Yes	O No
Scarlet Fever	O Yes	O No
Shingles	O Yes	O No
Sickle Cell Disease	O Yes	O No
Sinus Trouble	O Yes	O No
Spina Bifida	O Yes	O No
Stomach/Intestinal Disease	O Yes	O No
Stroke	O Yes	O No
Swelling of Limbs	O Yes	O No
Thyroid Disease	O Yes	O No
Tonsillitis	O Yes	O No
Tuberculosis	O Yes	O No
Tumors or Growths	O Yes	O No
Ulcers	O Yes	O No
Venereal Disease	O Yes	O No
Yellow Jaundice	O Yes	O No

Have you ever had any serious illness not listed above? O Yes O No ____________________

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex O Sulfa Drugs

O Other If yes, please explain: ____________________

Comment: ____________________

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________________ DATE __________

NAME OF PATIENT, PARENT, or GUARDIAN (Print) ____________________

WITNESS SIGNATURE ____________________ DATE __________

DR. SIGNATURE ____________________ DATE __________

DENTAL HISTORY

Approximate Date of last cleaning ____________________

Procedure(s) done at last dental visit ____________________

Are you looking for a change in the way your smile looks? O Yes O No

If you could change anything about your teeth, it would be (Check all that apply)

O Color of your teeth
O Size/Shape of your teeth
O Gaps between your teeth
O Too much or too little of teeth show when you smile
O Too much or too little gum shows when you smile
O Alignment of your teeth

O Other (Please describe) ____________________

Do you have? (Check all that apply)

O Sensitive or receding gums
O missing teeth
O Teeth sensitive to heat / cold
O Concern about bad breath
O Worn / broken / chipped teeth
O Old crowns that have dark edges at the top
O Teeth sensitive while chewing
O Old or discolored fillings

O Other (Please describe) ____________________

Have you ever experienced? (Check all that apply)

Periodontal disease / gum treatment O Yes O No
Orthodontics treatment O Yes O No
Oral Surgery / wisdom teeth O Yes O No
A bite plate or mouth guard O Yes O No
Snoring O Yes O No
Discomfort in your jaw join (TMJ/TMD) O Yes O No
Your bite adjusted or balanced O Yes O No
Serious injury to the mouth or head O Yes O No
Chronic bad breath O Yes O No
Grinding of teeth (day or night) O Yes O No

If yes to any of the previous questions, please describe ____________________

Do you require antibiotics before dental treatment? O Yes O No

If Yes, why? ____________________

Have you ever taken, currently take, or plan to take medication for osteoporosis? (Biophosphonates) O Yes O No

Is there anything else about your past dental treatment(s) that you would like to know?

SIGNATURE DATE

PHOTOGRAPHY RELEASE

I____ , hereby authorize TRUDENT AGIZ VE DIS SAGLIGI

HIZMETLERI A.S to take photographs and videos of my face, jaws, and teeth.

I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publications or as part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

____ ____________________________

Signature Date

PRIVACY

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

The Purpose of this form is used to obtain written acknowledgement of Receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, ______________________________________ , have received a copy of this Notice of Privacy Practices.

______________________________________ ______________________________________

Please Print Name Signature of Patient or Guardian

______________________________________ ______________________

Relationship To Patient Date

For Office Use Only

We attempted to obtain written acknowledgement of recipe of our Notice of Privacy Practices but, acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Republic of Turkey Law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the Privacy Rules of Republic of Turkey for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends:

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, MOH oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and • as authorized by worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

You may contact us using the information listed below. You also may submit a written complaint to the Turkey Minister of Health Services. We will provide you with the address to file your complaint with the Turkey Minister of Health Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the Turkey Minister of Health Services.

THANK YOU!

FOR CHOOSING TRUSMILE

Dr. Murat Sutpideler & Team